SOUTH DAKOTA BOARD OF NURSING
SOUTH DAKOTA DEPARTMENT OF HEALTH
4305 S. LOUISE AVENUE SUITE 201 ♦ SIOUX FALLS, SD 57106-3115
(605) 362-2760 ♦ FAX: 362-2768 ♦ www.state.sd.us/doh/nursing

NURSING EDUCATION ASSISTANCE LOAN APPLICATION

FORM A: STUDENT STATUS

RN: *Submit to the Board of Nursing by June 1st of the year in which the Application is to be considered.*
LPN: *Submit to the Board of Nursing by October 1st of the year in which the Application is to be considered.*

STUDENT APPLICANT NAME: _____
FIRST MIDDLE MAIDEN LAST

ADDRESS: _____
STREET CITY STATE ZIP

DATE OF BIRTH: _____ SS #: _____ TELEPHONE: _____

EMAIL: _____ US CITIZEN: ❒YES ❒NO LENGTH OF RESIDENCY IN SD: _____

Are you a licensed nurse? ❒YES ❒NO If YES, where? _____ Expiration: _____

I am currently accepted/enrolled in (Nursing Education Program): _____

❒Diploma in Nursing
❒Practical Nursing
❒Associate Degree in Nursing
❒Baccalaureate in Nursing
❒Masters Degree in Nursing
❒Doctorate in Nursing

SPECIAL PROGRAM
❒Clinical Nurse Specialist
❒Nurse Anesthesia
❒Nurse Midwife
❒Nurse Practitioner
❒Other (please specify): _____

AFFIDAVIT & RELEASE OF INFORMATION AUTHORIZATION

- I declare that I am the person referred to in this Application, as specified in SDCL 36-9 and ARSD 20:48:13; all statements herein are true and correct to the best of my knowledge and belief.
- I authorize the above named program of nursing education to release the information requested below to the South Dakota Board of Nursing for purposes of determining eligibility for nursing loan assistance.

SIGNATURE OF APPLICANT: _____ DATE: _____

ADMINISTRATOR OF NURSING PROGRAM: Please complete this section, then return this form to the student applicant.

Date Accepted into Nursing Program: _____

Expected Date of Graduation: _____

Cumulative GPA (if applicable): _____

Nursing Student Status for the Upcoming Academic Year:
❒ FRESHMAN
❒SOPHOMORE
❒JUNIOR
❒SENIOR
❒GRADUATE STUDENT

_____
SIGNATURE OF NURSING PROGRAM ADMINISTRATOR DATE

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NURSING EDUCATION ASSISTANCE LOAN PROGRAM

FORM B: FINANCIAL AID INQUIRY

RN: *Submit to the Board of Nursing by June 1st of the year in which the Application is to be considered.*
LPN: *Submit to the Board of Nursing by October 1st of the year in which the Application is to be considered.*

STUDENT APPLICANT NAME: _____
FIRST MIDDLE MAIDEN LAST

DATE OF BIRTH: _____ SS #: _____

AFFIDAVIT & RELEASE OF INFORMATION AUTHORIZATION

- I declare that I am the person referred to in this Application, as specified in SDCL 36-9 and ARSD 20:48:13; all statements herein are true and correct to the best of my knowledge and belief.
- I authorize the above named program of nursing education to release the information requested below to the South Dakota Board of Nursing for purposes of determining eligibility for nursing loan assistance.

SIGNATURE OF APPLICANT: _____ DATE: _____

FINANCIAL AID OFFICER: Please complete this section, then return this form to the student applicant.

Include only direct educational expenses (tuition, books, and fees) in the estimated total expenses.
Room and board are not considered direct educational expenses.

❒Not eligible for Title IV Aid
❒Did not apply for Title IV Aid

TOTAL EDUCATIONAL EXPENSES FOR ACADEMIC YEAR (TUITION, BOOKS, FEES ONLY)		**$**

GRANT(S)	Federal Pell Grant	$
	Supplemental Educational Opportunity Grant	$
	Other:	$
SCHOLARSHIP(S) (PLEASE SPECIFY)		$
		$
		$
BENEFIT(S)	Veteran's Benefits	$
	Social Security Benefits	$
	Bureau of Indian (BIA) Benefits	$
	Other:	$
TOTAL GRANTS, SCHOLARSHIPS, BENEFITS		**$**

TOTAL EXPENSES – TOTAL GRANTS, SCHOLARSHIPS, BENEFITS = UNMET NEEDS	**$**

_____
SIGNATURE OF NURSING PROGRAM FINANCIAL AID OFFICER DATE